

Advancing the Sexual and Reproductive Health and Human Rights of People Living With HIV

**Report of study on the uptake of
prevention of mother to child
transmission of HIV (PMTCT)
services by people living with HIV in
Nairobi, Kenya**

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Acronyms

AIDS	Acquired Immune Deficiency Virus
ANC	Ante-natal Clinic
APHIA II	AIDS Population and Health Integrated Assistance II (USAID) project
ART	Antiretroviral Therapy
ARV	Antiretroviral
CCC	Comprehensive Care Centre
DASCO	District AIDS/STIs Control Coordinator
DHMT	District Health Management Team
DPHN	District Public Health Nurse
DPHO	District Public Health Officer
FGDs	Focus Group Discussions
FP	Family Planning
HAART	Highly Active Antiretroviral Therapy
HIV	Human Immunodeficiency Virus
HRH	Human Resource for Health
IEC	Information, Education and Communication
IUD	Intra Uterine Device
KAIS	Kenya AIDS Indicators Survey
KENWA	Kenya Network of Women with AIDS
KNASP	Kenya National AIDS Strategic Plan
MCH	Maternal and Child Health
MOH	Ministry of Health
MoMS	Ministry of Medical Services
MoPHS	Ministry of Public Health and Sanitation
MoSPA&IS	Ministry of State for Planning, National Development and Vision 2030
NACC	National AIDS Control Council
NASCOP	National AIDS and STIs Control Programme
NEPHAK	National Empowerment Network of People living with HIV and AIDS in Kenya
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-To-Child Transmission
RH	Reproductive Health
STIs	Sexually Transmitted Infections
SRH	Sexual and Reproductive Health
SRHR	Sexual Reproductive Health Rights
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WOFAK	Women fighting AIDS in Kenya

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The Advancing the Sexual and Reproductive Health and Human Rights of People Living With HIV: A Guidance Package is one of five evidence-gathering tools being implemented through the HIV Leadership through Accountability programme. The programme combines specific HIV evidence-gathering tools, national AIDS campaigns and targeted advocacy to achieve Universal Access to prevention, treatment, care and support. For more information about the HIV Leadership through Accountability programme please visit www.hivleadership.org.

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Executive Summary

Introduction and Background

Although there are ongoing efforts to scale up prevention of mother to child transmission of HIV (PMTCT) services, the coverage and utilization still remains low. The enrolment into PMTCT programs is sub-optimal, the uptake of HIV counseling and testing has improved but there is a high drop-out rate from follow up. The use of antiretroviral drugs (ARV) by women to prevent vertical transmission is low and adherence is unknown especially among clients who are not linked to support groups offering adherence counseling and group therapies. Overall, the effectiveness of PMTCT services in HIV transmission risk is known largely among support group members and people who have accepted their HIV positive status.

Study Purpose and Description

The main purpose of the study was to assess information about sexual and reproductive health and rights (SRHR) especially PMTCT needs and experiences of people with HIV (PLHIV) in Kenya in order to inform efforts aimed at increasing access to SRHR services for people living with HIV. The overall objective of this study was to implement mapping tools which have been developed by and for PLHIV to gather evidence about key issues that affect PLHIV purpose of advocacy for PLHIV networks. However, the specific objectives of this research were to;

- Conduct qualitative research in consultation with NEPHAK on the rollout of the SRHR Guidance Package
- Review and present summary of most recent and relevant literature on Sexual and Reproductive Health among PLHIV in Kenya, specifically on PMTCT
- Provide oversight in the implementation of the study and train/supervise Research Assistants
- Supervise data entry, verify and analyze data
- Present the research findings to local stakeholders and partners.

The Study

The study looked at the current state of Sexual and Reproductive Health and Rights of PLHIV in Kenya with a focus on PMTCT and general prevention with positives. Based on time and resources constraints, the study was done in Nairobi East district, Nairobi Province between 2nd and 27th November 2009. Data was collected from representatives of the Ministry of Medical Services and Ministry of Public Health and Sanitation, clients accessing services from

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health facilities and support groups within Nairobi East district. Nearly 71% of the study respondents were drawn from support groups located in the informal settlements within Nairobi. It looked at the level of awareness, acceptability and accessibility of PMTCT services including the level of uptake of PMTCT services by PLHIV, an assessment of other available RH/FP services for PLHIV and availability of services for screening/preventing and treating other pre-disposing conditions such as sexually transmitted infections (STIs) and opportunistic infections (OIs). The information from this study provides evidence about key SRHR issues that affect PLHIV and will be used for advocacy to influence policy and practice.

Findings

The study was done and presented in three thematic areas; policy framework for HIV/AIDS/PMTCT in Kenya, Health Systems and Service Delivery.

Policy Framework

This chapter presents an analysis of the environment in Kenya regarding the policymaking process, existing HIV/AIDS and SRH policies, and the extent of awareness of the policies at all levels. It also assesses the extent to which these policies have been implemented in Kenya and whether they address HIV/AIDS and PMTCT. The data was obtained from interviews with policymakers who are members of Provincial and District Health Management Teams representing both Ministries of Medical Services (MoMS) and the Ministry of Public Health and Sanitation (MoPHS), District Public Health Nurse (DPHN), District Public Health Officer (DPHO), District AIDS/STIs Control Coordinator (DASCO), Provincial Home Based Care Coordinator and PMTCT Coordinator.

Policy development – With civil society often paving the way, Kenya has responded rapidly to the HIV epidemic through the development of various policies and guidelines to support delivery of HIV/AIDS services, including VCT, PMTCT and ART. These policies and guidelines are developed through consultation and consensus with a broad range of stakeholders. PMTCT is addressed in the National PMTCT Guidelines, the ART Guidelines and to some extent the Sexual and Reproductive Health Guidelines.

Policy Awareness – The level of awareness of these policies varies from one individual to another. Those at the policy and health care service provision levels are aware of the existence and role played by these policies. Nevertheless, some of the health care service providers said that they had not seen some of the policy documents since they were hard to access. Unfortunately, at the community level, awareness of the HIV policies is minimal with some members reporting total ignorance of policy. For instance, one participant in the study wondered how PLHIV would benefit from the policies.

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Policy implementation – At the implementation level, translation of policies into practice varies greatly across the HIV and AIDS programmes. The major service providers in Nairobi such as Mbagathi, Kenya Network of Women with AIDS (KENWA), Women fighting AIDS in Kenya (WOFAK) and Coptic Church Services reported that PMTCT is an integral component of their services. Indeed PMTCT services were understood in these setups and to a large extent, the clients willingly accepted PMTCT interventions with most facilities providing Nevirapine and AZT. SOS Medical Centre was however learnt to have moved to triple therapy.

Service Delivery

In this Chapter, the study looks at the PMTCT services available in clinic set-ups, efficiency of PMTCT services such as waiting time and service time; and other factors including, affordability, accessibility, acceptability, community characteristics, provider characteristics and patient-provider characteristics.

Waiting time – The study indicates that clients wait for an average of 2 hours; a finding that highlights the cost of time lost when clients use PMTCT services, given that they have other household chores. This factor negatively affects PMTCT enrollment.

Service time – Clients reported being served for an average of 15 minutes and 62% felt that they were not properly served. In addition, they reported that counseling e.g. infant feeding options was done in a group therefore rendering it ineffective.

Affordability – Although PMTCT is free, 31.8% (17 of the mothers interviewed) reported that some potential clients were barred from using the health care services including HIV counseling and testing by the costs of opening up an antenatal clinic (ANC) profile book which ranges from Kshs 50 to 100 varying from one health facility to another and the cost of other services such as laboratory tests or ultra sound scans.

Accessibility – With decentralization of services, the PMTCT clinics are easily accessible with the clients either going on foot or using public transport at a cost of 20 Kenya Shillings (Kshs). Accessibility becomes an issue in the event of referrals where by the client has to meet the costs of transport and the services referred for.

Acceptability – The level of acceptability of PMTCT services has improved with many mothers understanding the importance of PMTCT i.e. preventing HIV transmission to the infant. Challenges are however faced in making decisions about infant feeding options, child delivery options and FP methods during pregnancy.

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Community characteristics – The community largely contributes to the success or failure of PMTCT interventions. Mothers who reported negativity from the community experienced a lot of challenges during infant feeding. Some reported that they nearly gave up the use of infant formula (substitution feeding) just to please the community and to escape HIV-related stigma.

Provider characteristics – 2 clients reported that the providers in these facilities especially VCT were very young girls who concentrated more on sex and personal issues during their counseling sessions. They felt that this created discomfort which can impact negatively on the programs. Some of them especially those in the public facilities did not impress clients as staff who could be trusted to maintain confidentiality.

Patient-provider characteristics – Over 65% of the clients interviewed reported that the service providers have remarkably improved their relationship with clients though some were still viewed with mistrust based on the way they receive and attend to clients.

Health Systems

The chapter on health systems addresses; staffing, referrals and external linkages, availability of IEC material on PMTCT and SRH at PMTCT/HIV settings, provider training, integration of services and commodities and supplies.

Staffing – The gaps in staffing were reported to have largely contributed to the long waiting hours and short service time at the health facilities.

Referrals and external linkages – The main referral hospitals in Nairobi are Mbagathi District Hospital and Pumwani Maternity Hospital. However there is no formal coordination between the referring facilities and the specialized facilities. The facilities that host support groups have more connection to the community than those that are not. There is lack of documentation on referrals for both private and public facilities as well as a feedback mechanism to show that the client referred has been supported.

Availability of information, education and communication (IEC) material on PMTCT and SRH at HIV/PMTCT settings – There is limited availability of IEC material on PMTCT and materials that clients can carry home are especially needed. The available material is hanged on the walls and in most cases it is outdated. In addition, most of the material is written in English which is not understood by many of the clients. A number of facilities have video machines and TV sets at the waiting area but they are mainly used for entertainment rather than for education for which they are intended.

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Provider training – Service providers have acquired a range of HIV related skills with the providers from the public facilities having advantage over those in private facilities in this regard. Some of the skills include ART administration, diagnosis and management of opportunistic infections, encouraging compliance and adherence etc. There is need to train the auxiliary staff to complement the service providers in delivering HIV/PMTCT services.

Integration of services – The MOH has put a lot of effort in ensuring that all HIV services are integrated in the health facilities. Although this has not been fully achieved, there have been remarkable improvements in most facilities in Nairobi which provide a number of services including FP (condom, pills and injectables), STIs diagnosis and management, PMTCT, treatment of opportunistic infections and ART. Gaps still exist in diagnostic areas especially CD4 and viral load testing, X-ray, laboratory tests and scans.

Commodities and supplies – Inconsistent access to ARV supplies and drugs for other opportunistic infections is a serious systemic weakness. The frequent stock outs that are experienced in the country lead to many missed opportunities in HIV/PMTCT interventions. Stock outs were reported in Dandora II and Kayole Health Centre.

Documentation – Although a lot is being done in Nairobi, not all of it is being documented and shared nationally. There is marked achievement with PMTCT especially with the promotion of exclusive breastfeeding for 6 months but this success story is not well documented especially where the intervention is not donor funded. Male involvement is an issue which needs to be researched on and recommendations made on what interventions to initiate.

Introduction

1.1 Kenya Context

Kenya is situated in the Eastern Coast of Africa across the equator. It is bordered by the Indian Ocean on the East, Somalia on the North-East, Ethiopia on the North, Sudan on the North-West, Uganda on the West and Tanzania on the South (Encyclopedia of Nations). The country is divided into 8 administrative provinces; Nyanza, Coast, Eastern, North-Eastern, Central, Western, Rift Valley and Nairobi (Ministry of State for Provincial Administration and Internal Security, MoSPA&IS).



1.2 Demographic Profile

In 2007, the population of Kenya was estimated at 37 million. Approximately 50.5% of the population is female. The population is young with 42% aged below 15 years and only 2% above 65 years (Population Reference Bureau, 2007). The age and sex structure of the population is 'expansive' characterized by rapid growth and the size of each birth cohort being larger than the previous one (Korenjak-Cerne et al, 2008). The crude birth rate is 39% per thousand and an estimated 1.5 million births occur annually (Central Bureau of Statistics, 2004).

1.3 HIV and AIDS Situation

Kenya has a mixed human immunodeficiency virus (HIV) epidemic characterized by a prevalence of 7.1% in the general adult population (15-64 years) and prevalence between 15% and 50% among most at-risk-populations (MARPs) identified as commercial sex workers, same sex partners, prisoners, personnel of the uniformed forces, intra-venous drug users and individuals in HIV discordant relationships (NACC, 2008)

In 2007 an estimated 1,417,000 people were living with HIV in Kenya, of whom 140,000 were children aged between 0 – 14 years. There were 250,000 adults eligible for anti-retroviral therapy and 40 percent were on treatment (NACC, 2008).

Gender and urban-rural disparities: HIV prevalence among adults 15-64 years is higher in the rural areas (8.4%) compared to the urban areas (6.7%). The burden of disease is also higher in the rural area since 75% of the population are rural dwellers (NASCO, 2008b). Although the HIV prevalence in the general population has declined from a peak of 14% in the year 2000 to 7.1% in 2007, there is a trend toward 'feminization' of the epidemic (NACC, 2007). HIV prevalence in women is higher than that in men in the general population, between 15 – 64 years (8.7% compared to 5.6%). The population-based survey in 2007 found the difference to be statistically significant up until 34 years. In the age group 15-24 years, women are four times more likely to be HIV infected than men (6.1% compared to 1.5%) (NACC, 2008; NASCO, 2008b). In both rural and urban areas, women had a significantly higher prevalence of HIV than men. The difference in rural and urban areas is marginally significant among women (10% compared to 7.8%, respectively), but not significant among men (6.1% compared to 5.2%, respectively).

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Table 1: HIV prevalence among women and men by five-year age group, Kenya 2007 KAIS

	Women		Men		Total	
Age group (years)	HIV infected (%)	Total number tested	HIV infected (%)	Total number tested	HIV infected (%)	Total number tested
15 - 19	3.5	1,328	1.0	1,175	2.3	2,503
20 – 24	7.4	1,598	1.9	1,034	5.2	2,632
25 – 29	10.2	1,345	7.3	874	9.1	2,219
30 – 34	13.3	1,154	8.9	772	11.6	1,926
35 – 39	11.2	950	9.3	678	10.5	1,628
40 – 44	9.4	742	10.2	576	9.7	1,318
45 – 49	8.8	732	5.6	549	7.5	1,281
50 – 54	7.5	519	8.3	425	7.8	944
55 – 59	4.7	425	2.3	380	3.6	805
60 - 64	1.7	256	3.4	341	2.7	597
Totals						
15 - 24	5.6	2,926	1.4	2,209	3.8	5,135
15 - 49	8.8	7,849	5.5	5,658	7.4	13,507
50 - 64	5.2	1,200	4.7	1,146	5.0	2,346
Total (15–64)	8.4	9,049	5.4	6,804	7.1	15,853

1.4 National Response

The national response to HIV and AIDS in Kenya has evolved considerably. The first case of AIDS death publicly reported in Kenya was 1984. While it took the government a decade to have a coordinated national response, the religious community and civil society began their response early in the epidemic (Haddad et al., 2008). The following are the landmarks of the national HIV/AIDS response since 1984:

During the finalization of this study, the country had unveiled its third National AIDS Strategic Plan (KNASP 111) which replaced KNASP 11 and is geared towards the delivery of Universal Access to services. The first national strategic plan (The Kenya HIV/AIDS Disaster Response Programme 1999/2000 – 2003/04) was developed immediately the epidemic was declared a national disaster in 1999. By and large, the first national AIDS Strategic Plan responded to HIV/AIDS as an emergency.

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The second Kenya National AIDS Strategic Plan (KNASP II) 2005/6-2009/10 was developed with exemplary participation from government and stakeholders, and in line with the 'Three Ones' principles of "One Coordination Agency", "One Agreed Action Framework" and "One Agreed M&E system". NACC, led by a Board of Directors comprised of senior policy makers from all sectors of society, including Permanent Secretaries of key ministries, and senior representatives from the private sector and civil society, is the custodian of the 'Three Ones' principles approach in Kenya.

KNASP II provided a sound framework within which sectoral and civil society-led strategies, plans and budgets could be formulated, implemented and monitored. To achieve an overall prevalence target of below 5.5 per cent by 2010, KNASP II set three priority areas: (1) prevention of new infections; (2) improving the quality of life of people who are infected or affected by HIV/AIDS; and, (3) mitigating the socio-economic impact.

Towards the end of 2008 two important new sources of information became available – Kenya AIDS Indicator Survey (KAIS) and the Modes of Transmission study (MoT) – which had significant implications for KNASP II. Subsequently, NACC leadership, in consultation with stakeholders, agreed that the Mid-Term Review (MTR) for KNASP II, scheduled for November 2008, should be upgraded to a 'Summative Strategic Review', immediately followed by the development of a new KNASP Strategic Plan covering the period 2009/10 – 2012/13. The process to develop KNASP III paid close attention to sexual and reproductive health and rights of people living with HIV, including aspects of prevention with people living with HIV.

1.5 HIV and AIDS Programming

Considerable progress has been made under the last two National Strategic Plans in Kenya. Evidence show that the cumulative number of VCT and PMTCT together has grown from 1.7m in 2005 to more than 4.6 m at the close of 2007. The number of VCT sites (excluding PMTCT) sites has also increased from 3 in 2000 to almost 1,000 countrywide (960) in 2007. Regrettably, only 36% of Kenyan adults know their HIV status; and, 80% of HIV infected people do not know their status (KAIS, 2008). At the same time, by December 2006, 64% of facilities were providing PMTCT to 60-70% of all pregnant women who tested positive for HIV. Over 1000 ANC sites now offer PMTCT. Significantly, the national target of introducing PMTCT to 80% of health facilities offering antenatal care by 2007 has been met.

There have also been important changes in risk behaviour. Condom use at last higher-risky sex shows substantial progress for both women (23.9% in 2003 KDHS - 35.0% in 2007 KAIS) and men (4.6% - 51.8). It is encouraging that HIV prevalence among STI patients is reported to be declining – 19.1% in 2006 compared with 21.5% in 2005; overall, linkages between STI clinics and CT services remain weak yet, according to KAIS, one-third of Kenyans age 15-64

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years (81% among those with HIV) are infected with HSV-2; over half of the adult females are infected with HSV-2.

Although there are reports of massive scale-up of treatment and care in the last few years, between only 38-45% of those in need of treatment are being reached at present, with coverage for children much less at about 15%; at least 30,000 of those on ART receive nutritional support. Up to 300,000 Kenyans still at the risk of dying because they lack treatment access. Worse still, 70% of PLHIV live in rural areas, but services are concentrated in urban/peri-urban areas. The threat of TB among PLHIV is high and increasing. Although official data show that 80% of TB patients being offered HIV testing and 80% of TB facilities providing HIV testing to patients, only 27% of TB patients who are HIV+ are on ART.

The plight of orphans and children made vulnerable with HIV/AIDS is still un-addressed. The national cash transfer programme for destitute families has only reached 37 districts of the needy 150 districts. HIV-related stigma remains high particularly among professionals and Islamic communities living in the Northern frontier of Kenya.

1.6 Nairobi Province

Demographic profile

The population of Nairobi Province was estimated at 3,038,000 in 2005 with a growth rate of 2.6% per year. The population is young, 52.9% being below the age of 20 years. The dependency ratio (i.e. the proportion of the population aged below 15 years and above 65 years who are dependent on the productive labour force of 15-65 years) is 80.1%. The unemployment rates are high; 55% in the informal settlements and 45% in the formal settlements. It is estimated that half of the population are unable to satisfy their daily caloric intake requirements while 19% meet both their daily food and non-food requirements (KNBS, 2007 & 2008).

HIV epidemiology

The HIV epidemic's profile in Nairobi is similar to the national picture. An estimated 183,000 people were living with HIV in the Province in 2007. HIV prevalence in the general population in Nairobi is 8.8%. Women are disproportionately affected, with a prevalence of 9.9% compared to 7.7% in men (NASCO, 2008b).

PMTCT Situation

Among women aged 15-54 years who experienced their last live birth between 2003 and 2007, 89.6% reported attending an ANC at least once during pregnancy. Annual rates of ANC attendance (defined as one visit or more prior to the date of delivery) during this time period were similar across year of birth. ANC attendance rates (at least one visit) were

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greater than 84% in Nairobi province. ANC attendance rates were high among all age groups, ranging from 85.4% among women aged 40-49 years to 90.8% among women aged 25-29 years. ANC attendance rates were significantly lower among women with no primary education (61.3%), when compared to women with at least some primary education or higher (90.8%-96.2%). ANC attendance progressively increased with increasing wealth quintile, from 76.7% in the lowest quintile to 96.3% in the highest quintile. In deed, as stated above the country had by 2007 met the national target of introducing PMTCT to 80% of health facilities offering antenatal care.

Study Background

There is evidence that without intervention there is 15 to 30% chance of HIV transmission in the non-breast feeding population and a total of 20 to 45% chance in the breast feeding population (WHO, 2007; De Cock et al., 2000). In the global north the risk of transmission has been reduced to less than 2% by combining universal access to antenatal care services, testing all pregnant women for HIV with an option to opt-out, access to combination long course antiretroviral treatment for viral suppression, elective caesarean section and access to alternative feeding options (Fowler et al., 2007; Suksomboon et al., 2007; WHO, 2004). In Kenya, meeting the above conditions still remains a challenge and the rate of HIV transmission rate from mother-to-child was still relatively high (32.8%) in 2006 with a national anti-retroviral (ARV) prophylaxis coverage of 40% (NACC, 2008).

A number of clinical trials have been conducted to determine the efficacy of antiretroviral drugs used alone and in combination to reduce the risk of mother-to-child transmission in resource constrained settings. Although comparison of various outcomes may not be practical due to differences in the study designs, durations of follow up, populations studied and measured outcomes, the emerging body of evidence suggests that combination anti-retroviral therapy is more efficacious than single-dose treatment, and that treatment begun in the early second trimester results in better risk reduction outcomes than treatment started late in the third trimester (Leroy et al., 2008; Leroy et al., 2005; WHO, 2004).

In Kenya, the national guideline on PMTCT outlines options for ARV prophylaxis depending on the timing of the first contact with a HIV positive pregnant woman. They distinguish between those seen between 28 and 38 weeks of pregnancy and those seen later or in labour. While the guidelines recommend combination short course antiretroviral prophylaxis with Zidovudine, Nevirapine and Lamivudine for the mother and infant as standard (NASCOP, 2008a), the minimum alternative of single-dose intra-partum Nevirapine is more widely used. There has been concern about the low effectiveness of this approach and its inherent increased risk of Nevirapine resistance that disadvantages the mother and infant. In 2003, a hospital-based study in Coast Province in 2003 among a breast feeding women found no statistically significant difference in the HIV transmission rate occurring among women given single-dose Nevirapine intra-partum (18.1%) compared to transmission rate (21.7%) experienced by women before any intervention was available in 1999 (Quaghebeur et al., 2004).

As indicated above, Kenya's target for PMTCT services as articulated in the Kenya National Strategic Plan (KNASP I) 2005/6 and KNASP II, was to comply with UNGASS goal of reducing the proportion of infants infected with HIV by 20% by the year 2005 and 50% by 2010

Unfortunately, utilization of PMTCT services has been lower than expected in Kenya, as it has been in other African settings including Uganda (Karamagi et al., 2006), Zambia (Stringer et al., 2005) and South Africa (Bassett, 2002). In order to prevent the new HIV infections in children, the gaps and barriers that limit the success of the prevention of mother-to-child transmission programs should be addressed. The benefit of PMTCT is undeniable. It is therefore of serious concern that many women and children fail to benefit from the available services while the opportunity to do so exists (UNICEF et al., 2008). A better understanding of the factors that contribute to the under-utilization of PMTCT services in Nairobi is essential for improvement of the services. This study will give insight into the level of awareness of PMTCT services and the access barriers and constraints that limit their utilization in Nairobi by PLHIV.

2.1. Study Purpose

The purpose of this study was to gather information about the PMTCT needs and experiences of people with HIV in Kenya in order to inform efforts to improve access to PMTCT services for people living with HIV. The overall objective of this consultancy is to implement mapping tools which have been developed by and for PLHIV to gather evidence about PMTCT related services that affect PLHIV for the purpose of advocacy for PLHIV networks.

2.2. Specific Objectives

The specific objectives of this study were;

- Conduct qualitative research in consultation with NEPHAK on the rollout of the SRHR Guidance Package, specifically PMTCT
- Review and present a summary of the most recent and relevant literature on PMTCT services among PLHIV in Kenya
- Oversee implementation of the study and train/supervise Research Assistants
- Supervise data entry, verify and analyze data
- Present the research findings to local stakeholders and partners

2.3. Methodology of Study

The study adopted both qualitative and quantitative approaches of data collections and therefore used an extensive document review; in-depth and semi-structured interviews with policymakers, members of health management teams, service providers and client exit interviews and focus group discussions (FGDs) with HIV positive clients.

Document Review

The study started with an extensive review of research and publications looking at provision and uptake of PMTCT services. The literature reviewed included available VCT, ART, PMTCT,

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SRH/FP policy documents; and strategic plans of key VCT, ART, PMTCT and SRH/FP implementing organizations. Information gathered from these documents was used to complement findings from the primary sources. A listing of the documents reviewed are presented in the reference section of this report.

In-depth Interviews

7 in-depth interviews were conducted with policymakers at the provincial level and district health management teams. The teams interviewed were Provincial Home Based Care Coordinator (PHBC), Provincial AIDS and STIs Coordinator (PASCO), Provincial PMTCT and VCT Coordinators, District Public Health Nurse (DPHN), District Public Health Officer (DPHO), District AIDS and STIs Coordinator (DASCO). Policymaker interviews provided insight into the policy environment in Kenya. They also flagged up recommendations regarding how to best address the constraints and challenges of PMTCT services delivery and uptake. Interviews with district health management teams yielded qualitative data on the realities of delivering PMTCT services. They also provided important perspectives and perceptions on the effects of attending ANC and giving birth at a health facility, the role of the family and community and need for follow up.

Semi-structured interviews

Semi-structured interviews on the delivery of integrated services were conducted with counselors and nurses in four VCT, ART and ANC/MCH sites. These were; SOS Medical Centre, Dandora II, Kayole Health Centre and Coptic Church Clinic, Industrial Area. Data was collected and collated on many aspects, including the delivery and subsequent usefulness of provider training, the effects of available protocols, the services provided, and the staff experiences, perceptions and recommendations for enhancing service delivery.

Exit Polls

At the study sites, 44 exit interviews were conducted among HIV-positive clients who had received services at the ANC. Their interviews related to whether they had prior knowledge of HIV and counseling and testing, the waiting time, service time, cost of the service, types and quality of services provided, disclosure of status to family and community, number of children born through PMTCT, level of satisfaction with services, and knowledge of human rights and PMTCT guidelines.

Focus Group Discussions

Focus Group Discussions (FGDs) were conducted among HIV positive men and women receiving PMTCT and SRH services as well as HIV-positive mothers currently/previously enrolled in PMTCT programs. These participants were conducted through their support groups, some of which provided these services or referred them to relevant facilities for PMTCT services. The selection of FGD participants was based on individual willingness to participate in the study and the people's openness about their HIV-positive status. In total

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50 people participated in 6 focus group discussions (each with 6 – 12 participants). 4 of the FGDs involved participants linked to support groups in informal settlements within Nairobi. The discussions were used to discuss clients' knowledge, attitudes and practices toward PMTCT services, and perceptions regarding the risk of having HIV positive children.

Table 2: Summary of FGDs Conducted in the Study areas

Support group	Number of male participants	Number of female participants
Oasis of Hope (Hope Centre, Kariobangi)	2	5
Blessed Brother Andrew (Catholic Church)	0	12
For Future Life (KENWA, Kariobangi)	1	8
KENWA, Soweto	0	6
WOFAK, Kayole	0	6
Eastern Deanery, Dandora	3	7
Total	6	44

2.4. Organization of the Study

Technical oversight to the study

Technical oversight of the study was provided by NEPHAK team, and the Consultant with backstopping support from the Global Network of People Living with HIV (GNP+).

Training of the Research Assistants

The data collection team was trained for 1 day. The training included orientation on data collection techniques. The training also covered the basic concepts of research, objectives of the study, the interviewer's role, identification and selection of respondents, negotiating consent, techniques of interviewing, problem solving during the interviews, and recording of the responses.

Pre-testing of the instruments

The FGD, client exit interviews and in-depth interview tools were pre-tested at SOS Medical Centre, KENWA Soweto and WOFAK Kayole to determine their suitability for collecting the required data. The results from these pre-test were used to refine the instruments and to enhance the data collection skills of the research assistants. All the instruments were written in English but the interviewers used Kiswahili which is a national language and is understood by nearly all Kenyans.

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Study Limitations

The study only captured the voices of people who actually accessed the PMTCT/HIV services. It also focused entirely on HIV-positive clients and thus did not capture the voices of clients who were not HIV positive. Only literature written in English was reviewed. As such, the experiences documented in other languages may have been missed. In regard to literature review, the National Data KAIS, 2007, did not reflect the current situation since a lot has been done since 2007 when the survey (KAIS) was done. This study was also done in Nairobi and its findings should be understood in that light.

HIV/AIDS/ PMTCT and the Policy Environment

This chapter presents an analysis of the environment in Kenya regarding the existing HIV/AIDS and SRH policies, and the extent of awareness of the policies at all levels. The chapter also assesses the extent to which these policies are implemented and whether they address HIV/AIDS, specifically PMTCT issues.

Relevant data for this chapter came from interviews with policymakers who were members of District Health Management Teams (DHMT) representing both the Ministries of Medical Services (MoMS) and the Ministry of Public Health and Sanitation (MoPHS). The DHMT members included District Public Health Nurse (DPHN), District Public Health Officer (DPHO), District AIDS/STIs Control Coordinator (DASCO), Provincial Home Based Care Coordinator and PMTCT Coordinator.

3.1 The Policymaking Process

The government of Kenya bears responsibility for developing national policies and guidelines, as well as monitoring implementation and compliance to these policies. This study sought to explore the process of policy development and found out that most of the health sector policies have been developed under the supervision of the Ministry of Health (MOH), which has the mandate to provide policy and guidance for healthcare. In many cases, initiation of a policy follows the identification of a need, which may be related to a new activity or an ongoing activity that requires more policy guidance or revision of an existing policy. The MOH may establish a technical committee or commission a consultancy to formulate a draft policy. Through workshops and meetings, stakeholders are invited to provide input and eventually reach final consensus on the draft, which is then sent to the Minister for approval. Once approved, the draft is presented to the Cabinet.

In addition to ensuring that policies address locally identified needs, efforts are made to ensure that policies are consistent with international standards, such as those defined by the World Health Organization (WHO), the United Nations Program on HIV/AIDS, the United Nations Population Fund, and other international bodies. Once the Cabinet has endorsed the draft, it becomes a national policy and is then ready for wide-scale dissemination. It should be noted that, even after being approved, the policy remains a living document and is amenable to revisions as necessary to better address the needs of the citizenry. For example, during this study, the National Policy Guidelines for PMTCT and ART formulated in

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2003, were currently undergoing revision to address newly emerging issues, such as the need to initiate treatment when an individual's CD4 count reaches 350 and the use of triple therapy for PMTCT.

The process of drafting HIV/AIDS and SRH policies in Kenya was reported to be participatory, involving wide-scale consultations among various stakeholders. The main stakeholders in policymaking include civil society organizations, networks of PLHIV, faith based organizations (FBOs), government representatives etc. It is worth noting that as in other developing nations, civil society activists have been catalysts for the fast pace of HIV/AIDS programming and policy development in Kenya. Overall, the major focus has been to ensure that policies are tailored to the local situations, are simple to comprehend and implement, and address the actual needs of the target population. Regardless of whether the policy is for VCT, ART, PMTCT, or RH programs, the development process is the same. Until recently, there has been little interface between policymakers and stakeholders involved in HIV/AIDS and FP/RH policymaking. The HIV/AIDS policy environment in Kenya has been dynamic. In situations where interventions such as ART are new, implementing organizations have created their own organizational policies ahead of national policies. For instance, NEPHAK and other PLHIV networks in Kenya operated within the international GIPA principles long before National AIDS Control Council's (NACC).

3.2 Existing HIV/AIDS Policies

Kenya's HIV/AIDS response has been multi-sectoral; involving the government, non - governmental organizations (NGOs), faith-based organizations, community-based organizations, networks of people living with HIV and private individuals. The multiplicity of HIV/AIDS interventions necessitated governmental coordination to ensure that services are consistent across providers and a minimum standard of quality is maintained. The government has tried to move rapidly in drafting policies and guidelines to support implementation of HIV/AIDS activities including VCT, ART, HBC, SRH, Nutrition and PMTCT services. But as mentioned previously, some NGOs have had to move even faster with their own organizational policies and guidelines for service delivery. At the national level, the following policies have been developed to guide delivery of HIV/AIDS services:

- Kenya National HIV/AIDS Strategic Plan (KNASP I, II and now III)
- Guidelines for Prevention of Mother to Child Transmission (PMTCT) of HIV/AIDS in Kenya
- Kenya National Guidelines on Nutrition and HIV/AIDS
- National Guidelines for HIV Counseling and Testing in Kenya
- Guidelines for HIV Testing in Clinical Settings
- The Kenya National ART Guidelines
- The National Home Based Care Guidelines

These policies and guidelines feed into the National AIDS/STIs Control Programme (NAS COP) which provides the overall policy and planning framework for HIV/AIDS in Kenya. At the implementation level, organizations adapt national policies and guidelines to fit with their operating structure and resources. For instance, the private VCT and ART/PMTCT organizations examined in this study have established guidelines and protocols to guide service delivery and to ensure that they deliver consistent and high-quality services across their various branches in the Nairobi. In the public health facilities, the VCT, ART, and PMTCT providers follow the standard national guidelines. In both cases, these guidelines are consistent with the national policies governing the respective services.

3.3. Awareness of the policies

Policy making level

At the policy making level, awareness of existence of these policies is clear and obvious. In addition, the policy documents were easily available and accessible at this level.

Service provider level

All the service providers reported awareness of the policies and guidelines with 50% reporting constant use/referral to some of the guidelines. Nearly 18% reported having been taken through the guidelines verbally. Although the service providers operated within the guidelines, the 18% had not seen the guidelines. Providers from private facilities reported that it was not easy to access the policy documents from the relevant offices. Only 1 health care provider had 2 of the 6 national policy guidelines.

Community (and/or client level)

At the community level, only 17% of the clients interviewed reported having knowledge of the existence of national policies on HIV/AIDS. Only 22% of those aware of the guidelines reported having seen a print copy of at least one of the guidelines. The rest had only heard of the existence of these guidelines from other people. The popular policy guidelines of which clients were most frequently aware included; VCT, ART and PMTCT.

3.4. Policy Implementation

With regard to use of the policies and guidelines all the service providers reported implementation of two or more of the policies with a slight variation between public and private facilities.

For example, the new PMTCT guidelines launched in Nairobi in August 2009 state that a combination of three ARVs – zidovudine (AZT), nevirapine (NVP) and lamivudine (3TC) will be used for mother and baby, rather than the single dose of nevirapine administered previously (a practice that led to some women and children developing resistance to the

drug). ‘With these guidelines we intend to move into more efficacious regimens,’ said Dr Sirengo, the PMTCT Programme Manager at the National AIDS/STIs Control Programme (NASCOP) says. He adds that although the government intends to phase out single-dose nevirapine in PMTCT altogether, the new drug regimen will take some time to implement as it involves additional costs and training for health workers. While all public facilities are still using dual therapy (AZT and NVP), one of the private facilities reported having added 3TC.

3.5. Legal and ethical issues

All (100%) of the respondents recorded knowledge of human rights (including the rights of PLHIV). But, over 65% overwhelmingly responded that the rights of PLHIV are not respected as evidenced by high stigma and discrimination level at all levels in the community and health facilities. For example one respondent had this to say; *“I can not refer anyone here for PMTCT services. This is because even the person conducting counseling already has a negative opinion about PLHIV, that we got infected because we were promiscuous.”*

Service Delivery

This chapter highlights the key findings from this study, especially those that relate to service delivery/provision.

4.1. PMTCT Services

The study findings indicate that the PMTCT clients received the following services in the ANC set up;

- HIV testing
- Ongoing counseling (including couple counseling)
- ARV prophylaxis
- Treatment preparedness
- Infant feeding counseling
- Nutrition counseling
- Diagnosis and treatment of STIs
- Management of OIs and HIV treatment
- FP service options
- IEC material on SRH/PMTCT and HIV
- Couples counselling

Almost all (91%) of the study participants recorded having received eight or more services of these 11 services related to PMTCT. Couple counseling was only received by 8% of the clients while 11% reported having been diagnosed and managed for STIs. The clients attributed the low couple counseling to the high level of denial among most men. The FP options found to be available within the facilities included condom and pills and the service providers encouraged clients to use dual protection. Over 90% of the mothers reported knowing their HIV positive status during their ANC visits. Six out of the 44 mothers interviewed reported that they had children born with HIV prior to their knowledge of HIV status.

Some providers noted that they often urge HIV-positive clients to limit their sexual activity to avoid deterioration of their health. However, many clients misconstrue this to mean that they should not be having sex because they are HIV positive. As a result of this misinformation, they conclude that they do not require family planning services.

Despite this, 45% of the HIV-positive women and men who participated in the exit interviews confessed that they had been sexually active during the past six months. Most

providers said that uptake of contraceptives — other than condoms — was/is low at their preferred centers. Only 20% of the respondents felt at risk of unintended pregnancy, while a few PLHIV were using any effective contraceptive method.

4.2. Efficiency of PMTCT Services

Waiting Time

The findings indicated that over 85% of the clients reported having waited for services for longer than 2 hours at one time or the other. The average waiting time in this study was 3 hours which is 2 hours longer than the acceptable waiting time of 1 hour. Observation revealed that services started after 9.00am and clients were kept waiting. This was noted to be a factor which would likely discourage potential clients from utilizing the services. As Bennett and Brown (1998) explain, an initial negative experience can discourage subsequent attendance, and this may contribute to low uptake of PMTCT services. The long waiting time constitute a significant cost in lost time for PMTCT clients given that their household chores are not attended to when they leave to come to the service provider. These findings indicate that waiting time impacts negatively on the utilization of PMTCT services highlighting the need for policy makers to review strategies to reduce the length of waiting time.

Service Time

General counseling addressing HIV testing, infant feeding options, disclosure and positive living are meant to assist clients in accepting and living with their HIV positive status. However, from this study, the short time spent on counseling for most clients may indicate or suggest a likelihood of inadequate attention to this important task.

During in-depth interviews clients could not recall information they received regarding PMTCT, even after counseling services. Clients from public facilities only made use of counseling services once during their first visit and did not choose to receive counseling on subsequent visits irrespective of HIV status. This suggests very limited rapport between counseling providers and their clients. Counseling service times ranged from 15 to 30 minutes with an average service time of 22.5 minutes. This is below the standard requirement for counseling articulated in the National Counseling Guidelines (NASCO) which is that counseling time should average 25 to 30 minutes per session and that each counselor should be required to see no more than 5 clients per day.

Affordability

PMTCT services and other HIV interventions are free of charge to the user at the point of service. The cost is met by the donor agencies with limited government budget allocation (Campbell & Stilwell, 2008). However, the poverty levels still impact negatively on the prospects of access to the services. This assertion was confirmed by poor people living with HIV who participated in this study. This is because “poverty impacts on the infrastructure of

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the health services, on the communities themselves and on the quality and amount of health information released; it affects relationships between people and it undermines the individual pregnant woman's sense of capacity to act" (Skinner et al., 2005).

Nearly 31.8% (17 mothers of the mothers interviewed) reported that some potential clients were barred from using the health care services including HIV counseling and testing by the costs of auxiliary services such as laboratory tests or ultra sound scans. This was heightened if the health care workers' attitude is not empathetic.

Accessibility

With increased decentralization of services, the clients reported that the facilities were very much accessible. They spent an average of Ksh.20 on public transport therefore accessibility was not viewed by the clients as a hindrance to PMTCT uptake especially where there were no complications calling for referrals to specialized facilities.

Acceptability

Acceptability influences health service utilization and was evaluated in the different aspects of individual, community, provider characteristics and patient-provider relationships. From the study, it was understood in this study that the aggregate interaction of these factors and the ways in which they intersected with other factors such as availability and affordability in sum determined the actual utilization of HIV counseling and testing services. The characteristics of individual clients that further affect uptake decisions include fear of knowing one's HIV status, perceived stigma, lack of knowledge about available services and mixed knowledge about HIV and PMTCT.

Community Characteristics

Community characteristics include enacted stigma and the cultural explanations such as those surrounding breastfeeding and pregnancy, which may be dictated by the community especially by elderly women and relatives. These may also have a negative impact on of PMTCT uptake. One PMTCT mother said this; "I am happy that we are now being told to breast feed exclusively for 6 months. At least I will not be under any pressure from my family and the community to breastfeed the child. My second born was on infant formula and it was very stressful."

Provider Characteristics

Providers' characteristics reported to affect uptake of services include; lack of staff motivation manifesting itself in form of low output, negative attitude towards the work and/or clients, work absenteeism, long waiting hours, lack of confidentiality and negative attitude expressed by the health care workers. Nine of the clients responded that they can't refer anyone for PMTCT services because of stigma and discrimination and prefer that people make their own decisions (without being referred) about whether or not to access

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these services. Only 11 respondents said that they can talk about their HIV status with anyone else including their family members. The other 42 said they cannot because of perceived stigma at family and community

Patient-provider Characteristics

This category of characteristics has mainly to do with the level of trust between the service provider and the client. Trust is a construct that determine staff performance and patient responsiveness. It is built upon workplace characteristics such as commitment to organizational goals, nature of human resource management practices and culture of fairness. This seems not to be working well as was observed by one respondent *“PLHIV are really being mismanaged by service providers. When we go to the hospital feeling sick, the service providers just look at us without examination deciding that we are fine only to come back to the facility after a few days with serious conditions that could have been sorted out earlier”*.

Health Systems

5.1. Staffing

Understaffing and high client load were found to be major problems in all the sites. Their impact on the quality of care was most severe in government and Nairobi City Council facilities.

In Dandora II Health Centre, for example, mothers in the PMTCT program reported that some of them did not understand why they were only counseled on two occasions as a group on infant feeding options. This indicates that some PMTCT programs are not providing comprehensive information and services to HIV positive women. Some respondents noted that they required individual counseling on certain occasions. Some expected have more time with the counselor to explore their individual issues.

One study participant observed: *“...I would have wanted to have a private session with the ‘doctor’ to share out some of my experiences at home and this has really disappointed me because I have learnt that getting these service providers to attend to you keenly is a problem. They are too busy. Like here, we are being served by 2 people and the clients are more than 50.” – PMTCT client on exit*

The staffing gaps notably contribute to long waiting hours at the health facilities. In some facilities, the VCT counselor doubled up as the infant feeding and nutrition counselor. The respondents also noted improved level of skill and professionalism in handling PLHIV within the health facilities. Attitudes of health care service providers were reported to have improved but there was need for more improvement especially in the public facilities.

5.2. Referrals and external linkages

The service providers reported that when clients who needed PMTCT services not offered at the facilities, they were referred to specialized facilities such as Mbagathi or Pumwani. Specific referral forms have been created by MOH and other actors such as USAID’s APHIA II project for this purpose. However, referral coordination between the referring facilities and the specialized facilities is still weak and, to a large extent, not formalized. In all the sites visited, for example, providers reported that no formal follow up mechanism exists to ensure that clients who are referred for further services make it to the facilities and actually receive the services to their satisfaction. They also lacked a directory on referrals.

In most of these facilities, the male condom is the main contraceptive provided. Clients who need other methods are referred to bigger facilities. There is no mechanism to ensure that they get the services they are referred for. However, a few service providers especially those from the private facilities reported follow up through peer educators to ensure that the contraceptive method is compatible with their ART regimen.

5.3. Availability of IEC material on PMTCT and SRH at the HIV/PMTCT settings

Service providers were asked about what IEC materials on PMTCT/SRH were available at their facilities to raise awareness of the need for PMTCT among clients. At the PMTCT sites, the most frequently used IEC material was a video shown in the waiting hall where mothers gather for services. It was reported, however, that the video is used to provide information on a wide range of maternal and child health issues. There were also charts, pamphlets, brochures and demonstration materials available.

5.4. Provider Training

Ideally, the effective delivery of PMTCT services requires that service providers are trained in skills that allow them to competently handle PMTCT needs in their settings. Service providers were asked about what aspects of ART they had been trained on.

All the service providers interviewed reported having received some training in HIV treatment. The training received may include HIV treatment; combination treatment therapy, drug toxicity, compliance and adherence counseling, treatment of opportunistic infections, PMTCT and/or RH/FP for PLHIV. However, there were wide variations in the scope of training received; with providers from public facilities reporting more training than those from private facilities. 2 out of the 3 service providers interviewed from public facilities reported that the skills learned are not regularly updated through refresher trainings but that they relied on their supervisors and protocols for guidance where things have changed. Auxiliary staff was not well-informed regarding HIV/AIDS and this was reported as resulting in insensitive handling of clients. For instance a client who had sought direction to the comprehensive care centre (CCC), where all HIV-related services were provided, reported having been answered as follows; “...the HIV place is in block D.”

5.5. Integration of services

Both service providers and clients noted that there has been remarkable improvement in integration of services. However, the progress was reported to be slow and the reason given for the slow progress is that most health systems are poorly resourced and clinics are struggling just to provide conventional services let alone new ones.

5.6. Commodities and supplies

Systemic weaknesses regularly fail to ensure uninterrupted supply of ARV drugs in many PMTCT programs. The resulting stock outs such as the ones experienced by Dandora II and Kayole Health Centre during the time of this study, lead to missed opportunities in PMTCT programs.

5.7. Documentation

A lot is being done on PMTCT but not all of it is documented. Private clinics did not keep records on couples who attend PMTCT clinics, thus missing an opportunity to gather data to strengthen male involvement. Male involvement is low and little effort is being made by the public facilities to improve it. Two private facilities SOS Medical Centre and Coptic Church Clinic Services reported having initiated community outreach activities on PMTCT.

Discussion

The success of scaling up PMTCT services depends upon the extent to which the policy, institutional and cultural barriers are addressed. From the literature it is clear that a holistic approach is required. To prevent the mother-to-child HIV transmission, the first requirement is to identify those at risk and support those who are willing to avoid unwanted pregnancies altogether. There is also need for intensified HIV prevention information and services targeting girls and women of reproductive age. It is of concern that in Nairobi one in five women miss this opportunity because they do not utilize the antenatal care services fully.

This study has also found that human resource for health (HRH) gaps contribute to the challenges of availability and acceptability of PMTCT services. The number of staff available to offer these services is acutely inadequate, and this problem is compounded by the disparity between public and private facilities in the distribution and level of training of health service workers. There is strong evidence of the need to train service providers from private facilities more comprehensively as well as to provide supportive supervision to improve provider counseling skills and continuously evaluate the PMTCT service responsiveness to the needs of its clients.

The availability of PMTCT services and its reliability in Nairobi is affected by the frequent interruption of commodities and supplies. While this can be attributed to the logistical constraints of procurement, distribution and storage, there is also evidence that the commodity and supply management system is currently weak, fragmented and inefficient.

The role of the community is important in the acceptability of PMTCT services. There is little literature from Nairobi that documents community engagement and the impact of community participation in PMTCT programs. Experiences from other sites, however, show that the mobilization of community awareness and involvement in programming can yield ownership, acceptance, higher service utilization and reduces stigma.

CONCLUSION AND RECOMMENDATIONS

Conclusion

PMTCT remains the key to addressing the incidence of new pediatric HIV infections. From the literature it is clear that when the scaling up of PMTCT services is on-going, the programs are faced with challenges of low enrolment, high loss to follow up, non-adherence to ARV prophylaxis and an unknown effectiveness at population level.

Nairobi's PMTCT program fails to reach nearly a quarter of the target population, those who do not use ANC services. ANC is one of the most important entry points to PMTCT services. Operational research is needed to look into the reasons for low utilization of ANC services in Nairobi. The proportion of pregnant women accepting HIV testing in Nairobi has improved since 2003. Routine HIV testing with an 'opt – out' option and couple-counseling have proved to be effective in improving uptake of HIV testing and should be considered for scale up in Nairobi.

The proportion of pregnant women accepting HIV testing in Nairobi has improved since 2003. Routine HIV testing with an 'opt-out' option and couple-counseling have proved to be effective in improving uptake of HIV testing and should be considered for scaling up in Nairobi and other parts of the country.

The numbers of available sites offering services are inadequate and their distribution is skewed. The picture is also reflected in the availability and distribution of service provider responsible for the delivery of services. According to Asiimwe et al. (2005), there is evidence that the engagement of non-medical personnel, lay counselors, peer educators, and mentor-mothers offers the psychosocial support required for women to go through the cascade of PMTCT services. The addition of such adjunct personnel should be considered as one possible way of increasing PMTCT uptake.

The inefficiencies of the commodities and supplies systems fail to support the PMTCT program in delivery of reliable and high quality services. There is need for orientation of health care workers towards more client responsive attitudes and practices while also mobilizing community awareness, involvement and support for PMTCT programs.

Integration of PMTCT services into reproductive health and mother child and new born services is important in improving uptake. Maternal assessment for eligibility and treatment

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with HAART reduces HIV transmission and improves both maternal and infant survival outcomes.

In Nairobi, documentation of the operational experience of implementing PMTCT programs is scanty. There is little literature examining the impact of policy and the, institutional and cultural barriers that affect the utilization of PMTCT programs.

In addition, evidence show that approval from male partners is critical considerations in women's decision making regarding taking an HIV test and further enrolling in PMTCT programs. The participants felt that a lot needs to be done to bring men on board to support PMTCT services. The women who were accompanied by their husbands 'sounded and looked' happier and healthier than the rest. They attributed this to the support they are getting from their husbands and family members. There is need therefore to incorporate and involve men in PMTCT services.

Recommendations

From the findings of this study, the researcher recommends the following for the improvement of PMTCT services in Nairobi and Kenya as a whole:

- Mobile outreach clinics be established to offer services to the hard to reach areas that are poorly serviced by static PMTCT sites be established
- Lay counselors be hired and trained to supplement the human resource capacity provided by health care workers currently providing counseling. These lay counselors should be trained in HIV counseling to offer psychosocial support and mentoring to the PMTCT clients on disclosure, hospital delivery and best infant feeding practices. The lay counselors will also assure a reasonable workload and enough time with individual clients.
- An effort be made to scale up routine HIV testing with an option to 'opt-out' and encourage couple counseling at all health facilities.
- There be a harmonization of the different supply chains from different health services into one to substantially strengthen the commodities and supplies management system
- Capacity building training for health care workers on clinical assessment to build laboratory capacity to evaluate eligibility for HAART and monitor treatment for PMTCT clients
- Engagement and orientation of community health workers in monitoring ARV prophylaxis and the early referral of mothers to health facilities. Community – based health information management should also be integrated into this training.
- Scale up of community action (in collaboration with the health facilities) to reduce stigma around HIV/AIDS, and to increase health promotion around issues such as

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HIV prevention and infant feeding in general be up scaled. These activities should include but not be limited to, health promotion campaigns and the involvement of community leaders, clinic and/or community based support groups and community health workers in provision of community and home based health promotion.

- Programmes to assist women with disclosure of their HIV status need to be strengthened, and ways be found for partners and families to be involved more in supporting the woman, her treatment and infant feeding decisions
- Supportive supervision should be strengthened and regular client exit interviews should be implemented to continuously evaluate the level of service responsiveness to clients needs.
- PMTCT services must be more fully integrated into reproductive health care services and services that monitor child and newborn health should be put in place
- Operational research to evaluate the experience of implementing the Kenyan PMTCT program should be conducted and documented
- Dual protection and dual method use be promoted and popularized. Ready access to family planning methods such as hormonal contraceptives and IUDs are needed in addition to condom. Although the VCT guidelines stress on dual protection, condoms are not always easily available at the ANCs. In addition, while the clients interviewed reported use of both condoms and pills, the service providers reported that PLHIV clients mainly picked condoms.

These issues clearly pose significant programming challenges that have to be delicately but thoroughly addressed to improve PMTCT services. As Kenya intensifies its efforts in fighting HIV/AIDS, integration of the key services in all HIV/PMTCT interventions is of critical. Their strategic importance to the prevention of further transmission of HIV as well as to optimizing the quality of life for people living with HIV/AIDS (PLHIV) can not be disregarded.

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